

# THE RHODE ISLAND MEDICAL JOURNAL



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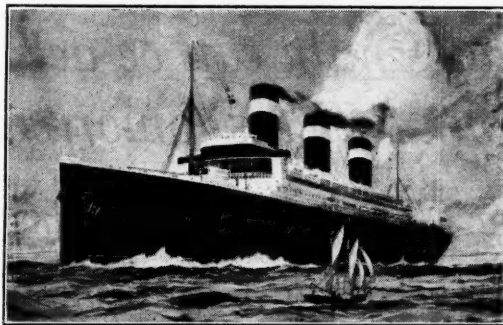
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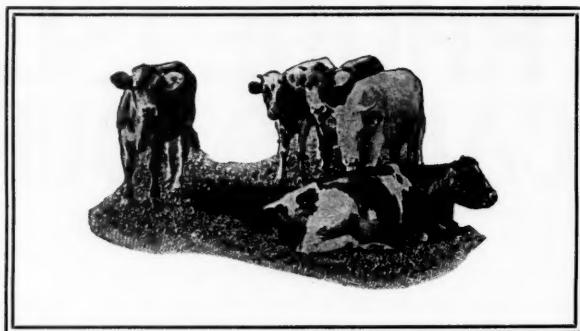
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VOLUME XI {  
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## ORIGINAL ARTICLES

### FOCAL INFECTION AND ITS RELATION TO OPHTHALMOLOGY\*

By FRANK J. McCABE, M.D.  
PROVIDENCE, R. I.

Systematic or general disease due to local infection is a conception as old as medical knowledge itself. Focal infection, however, is broader in its application than is the thought expressed by the term 'surgical sepsis.'

During the past twenty years, a new interest has been aroused in regard to focal infection as an etiological factor in local and general diseases. The renewed interest and increased knowledge of this subject has been developed by the application and deep study of such brilliant minds as those of Rosenow, Billings, W. H. Porter and others.

A focus of infection may be defined as a circumscribed area of tissue infected with pathogenic micro-organisms. These foci may be primary or secondary; the former are usually located in tissue which connects with a mucous or cutaneous surface. Secondary foci are the direct result of infections from other foci through contiguous tissue or from a distance, through the blood or lymph channels. Primary foci may be located anywhere in the body, but infections of the teeth and contiguous structures, the faucial tonsils, the para-nasal sinuses and the gastro-intestinal tract seem to be most common. Other areas of infection are the bronchi, lungs, auxiliary organs of digestion, and the genito-urinary organs.

Infected lymph nodes which are secondary to the primary foci, may be included as additional sources of local infection. This secondary lymph node infection may persist after the etiological or primary focus has been removed or has disappeared spontaneously. Other secondary foci may appear in various tissues as a part of the general or local disease. The infection may be carried by way of the blood stream in the form of emboli. The

severity of the infection is dependent upon the virulence and the specific pathogenic affinity of these bacteria and the character of the tissue and the function of the organ involved. The specific tissue reaction consists of a local inflammation with endothelial proliferation of vessel walls; hemorrhage into the surrounding tissue, positive chemotaxis with resulting increase in leucocytes and plasma cells in the infected area, or of a fibrinoplastic exudate. The infection may be spread by the lymph channels thus resulting in the invasion of the glands with the possible formation of a circumscribed abscess. It is now known that focal infection may cause anaphylaxis, the bacterial protein of the pathogenic micro-organisms sensitizing the body cells, thus producing bronchial spasm, urticaria, etc.

With the greater knowledge of focal infection, ophthalmologists are now better able to cope with eye conditions, which are known to be secondary to a focus elsewhere in the body. The most common infectious process is probably that involving the uveal tract, i. e., the iris, ciliary body and choroid. Other lesions noted are, affections of the second, third, fourth and sixth cranial nerves as well as inflammatory conditions of the cornea and retina and hemorrhages of retinal vessels.

Regarding the relative frequency of location of infectious foci, interesting information is found in the report of the very careful studies of Irons and Brown, on the etiology of iritis (and the same etiology would hold for the conditions just referred to above). This report is based upon a thorough study of two hundred cases of iritis: I shall read a statistical summary of their report:—

Infections	Alone	With Other Infections	Total
Syphilis .....	12	26	38
Gonococcal infection	8	2	10
T. B. ....	8	0	8
Dental infection .....	12	15	27
Tonsillar infection .....	26	27	53
Sinus infection .....	1	3	4
Genito-urinary (non-venereal) .....	6	0	6

\*Read before the Providence Medical Association, Dec. 5, 1927.

Other infections .....	3	0	3
No infection found.....			3
Combined infections.....		41	41
Undetermined .....		7	7
<hr/>			
Total	200		

According to these figures, infections of the teeth, tonsils and sinuses accounted for 42% of the cases. You will note that these authors found twice as many tonsillar infections as there were dental. My own experience would lead me to believe that there have been nearly twice as many dental as tonsillar foci. It is interesting to learn that in this series of cases there were but 19% which were due to syphilis. I appreciate that it is hazardous to attempt to draw definite conclusions from the study of so small a number of cases as two hundred and yet the picture shown by the figures which have been read to you, is sufficient, at least, to give us a basis for discussion.

Since the incidence of foci, in the teeth, tonsils and accessory sinuses is variously estimated to be between forty and seventy-five per cent, the question of "why," is a pertinent one. According to Gaudet, the reason is, because these infections take place along the beginning pathways of the respiratory and digestive functions. In the performance of the respiratory functions, which take place both through the nose and the mouth, there enters air, moisture, heat, smoke, dust, cold gases, irritating substances and bacteria, infective and non-infective, to which are exposed the mucous membranes lining these passages. There may exist, also, anatomical, mechanical and traumatic changes in the nasal and pharyngeal passages which interfere with proper ventilation and drainage of these areas. In the performance of the digestive function, there is taken into the mouth, all sorts of food, raw and cooked, uncontaminated and contaminated, hot and cold;—these often laden with pathogenic and non-pathogenic bacteria. These substances come in contact with all portions of the buccal cavity, including the teeth, gums, tongue, soft palate, tonsils, pharynx, etc. In other words, the greatest amount of substances necessary for the sustenance of life and the performance of the bodily functions, enter by way of the nasal and buccal cavities with a consequent entrance of much that is a direct cause of disease and infection.

Barry, writing in the *Journal* of the Medical Society of New Jersey, states that non-vital teeth are unquestionably a menace to the individual because recent microscopic studies have proven that most teeth have minute, collateral canals leading from the main pulp canal and forming a meshwork at the apex of the tooth. It is practically impossible to fill or sterilize these minute areas and yet they harbor millions of bacteria. He also says that many of these teeth present no areas of infection roentgenographically and yet, upon culture, they show virulent infections in 85 to 90 per cent of cases. This explains why so many retained de-vitalized teeth eventually cause alveolar abscess. Again, Barry says, that a thorough examination, in order to make a correct diagnosis, presupposes an initial roentgenographic examination because no dentist, without the aid of the X-ray, can assure the patient or the physician that possible contributory infections in the oral cavity have been eliminated. These foci are often the most dangerous of lesions because they develop no symptoms, are closed off by bony structures with little or no expansion and cause constant absorption.

The faucial tonsils being rich in lymphoid tissue, consisting of folds and crypts, are fertile fields for infection. It is said that more than 90% of all tonsils which have been carefully examined, showed pathological changes. Cultures taken from these tonsils have shown the various strains of strepto-coccus, such as: the mucosus, viridans and hemoliticus, the micro-coccus-catarrhalis, the different types of pneumococcus, the bacillus mucosus capsulatus, the influenza bacillus, the klebs-Loeffler bacillus, and many other pathogenic micro-organisms. Many children have a hyperplasia of the lymphoid tissue which goes to make up Waldeyer's ring. These are an ever-present source of infection. In adult life, small faucial tonsils may look innocent because of a smooth covering of mucous membrane but a careful examination may reveal infected crypts or even a frank abscess. Stumps of tonsillar tissue may contain infected crypts sealed over by post-operative scar.

We have been taught to believe that the gastrointestinal tract is a prolific source of general systemic infection and I am still of the opinion that such is true, in spite of the fact that this source was not listed as a focus of infection in the report

of Irons and Brown and as against the opinion of Billings, as expressed in his lectures on focal infection, in which he states in effect, that while many in the profession believe that stasis of the intestinal contents, due to constipation, congenital defects or acquired morbid anatomical conditions favor the presence of pathogenic bacteria, thus causing toxemia and systemic disease, and that there may be some truth in this belief, nevertheless, he is of the opinion that the pathogenic micro-organisms which enter the intestinal canal and remain there as infectious organisms, gain admittance by being swallowed, thus infecting the organs in the buccal cavity. He is inclined to the thought that appendicitis, cholecystitis and other local infections of the intestinal tract, are transmitted hematogenously from foci in the mouth and throat. But few of the sources of infection have been stressed. However, keeping in mind that every part of the body is a potential source, the discussion could be carried on indefinitely.

What has been said about focal infection and the various conditions of the eye, resulting therefrom, applies equally well to morbid conditions in other organs.

Unquestionably, it is the duty of every physician, having under his care patients whose ills can in any way be attributed to focal infection, to make a most thorough physical examination, seeking whatever aid he deems necessary, whether it be from colleagues engaged in the special fields or from examination of tissue, secretion, etc., by the laboratory men.

If the search is thorough and the source or sources are completely eliminated, we shall have less reason to resort to the terms, 'idiopathic' or 'rheumatic diathesis,' in explaining the etiology of certain chronic diseases.

In closing, let me say that I make no pretense of having said anything new. My only reason for having chosen the subject of focal infection was to emphasize the important part played by it in explaining the etiology as well as the chronicity of many bodily ills.

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### QUARANTINE OF SCARLET FEVER GOVERNED BY THROAT CULTURES\*

By EDWARD V. MURPHY, M. D.  
 HEALTH COMMISSIONER OF NEWPORT

The purpose of this paper is not to speak of the treatment of Scarlet Fever or of the clinical diagnosis, but more especially of bringing to your attention the results of the bacteriological side of the question in the diagnosis of the disease, and also our dependence upon the same method in the discharge of the Scarlet Fever cases.

As you know, the etiological factor in Scarlet Fever has been a question for a good many years, but within the last few years, particularly after the experiments of the Doctors Dick, it seems to be generally conceded that the cause of Scarlet Fever is unquestionably the streptococcus hemolyticus scarletina. And it is upon the basis of this discovery that the Health Department of the City of Newport has been depending in a great measure for the discharge of the cases of Scarlet Fever that have been quarantined at the Hospital.

We might say, incidentally, that the Health Department does not believe in the efficiency of quarantine at home, and we have encouraged all cases of a communicable nature to be sent to the Hospital. We find the results of that method are far more satisfactory than when cases remain at home. Inasmuch as the expenses are borne by the City, we are aided in inducing parents to send their children to the Hospital for treatment and observation.

Our partial dependence upon the bacteriological finding of the throat cultures has been of aid to us in diagnosis, in the quarantining of the cases; helps us to decide in doubtful cases; and the release from quarantine when the patient is apparently well.

\*Read before the Rhode Island Medical Society December 1, 1927.



The agreement that the s. h. s. is the cause of the disease has aided us who are doing health work, in reducing the period of quarantine. We all remember the time when it was believed that the exfoliated skin contained the germ that produced the disease, and how patients were kept under quarantine for weeks upon weeks, until every shred of skin that promised to exfoliate was removed. We now have no fear about exfoliating skin, and that in itself has reduced the period of quarantine, and with it, there has been an improvement in the economic side of the question.

Not the least important part of this method of handling the cases is the reduction in number of "return cases." This work has been done in the Health Department of the City of Newport for over two years, and in that period there have not been more than three return cases that could be attributed to the discharged case. Even return cases cannot always be attributed to the discharge case, because there is always the possibility in families where there are a number of children for one of the children to have an unrecognized case of Scarlet Fever, which could be very easily transmitted to another child, probably shortly after the discharged quarantined case. The natural tendency would be of course to blame the "return case" upon the discharged case, but that is not proof of the belief.

A number of epidemiologists although approving of the culture of cases ready for discharge, they have not done it. I have asked a number of experts in this line why, and their answers have not been convincing. One questioned the reliability of it; another felt it was not necessary, that the arbitrary confinement of four weeks was just as good as waiting for a culture from the throat being free from the organism. But in the course of our experience there was one occasion when the consulting epidemiologist insisted upon two negative cultures from the throat before admitting a sufferer from Scarlet Fever to return to his companions in school. That rather convinced us that perhaps way in back of the head of that expert he believed there was something of value in throat cultures in Scarlet Fever.

Unfortunately we do not have in scarlet fever throat cultures the same method of determining its virulence as we have in cases of diphtheria, and it may be that children are sometimes kept

in quarantine much longer than is absolutely necessary; but until we have a method of determining its virulence, or until we have evidence convincing us that the positive cases will not convey the disease, the Health Department feels that we should continue on this line of having throat cultures negative before discharge. (This has now been modified, and patients with negative throat cultures are discharged in 21 days, but positive throats cause patients to remain at least 4 weeks.)

There was one case of scarlet fever that we kept at home, and repeated throat cultures after three weeks were found to be positive, and continued so over a period of nearly two months.

Not the least important part of culture-taking is in diagnosis. We have all had the experience of seeing border line cases where the eruption is slight, where we are not sure about the throat, where there is a possibility of exposure of these cases to others. We have found in such suspects a negative throat with a doubtful eruption would point against scarlet fever, and so far we have not found the method getting us into trouble.

We have also adopted the plan of taking cultures at the end of three weeks. In scarlet fever cases where there has been no readily discoverable complication such as otitis media, or profuse secretions from the nose, or draining glands, or pus from any wound, we have in those cases cultured the throat, and finding them to be negative have discharged them from the hospital, and it is in the rarest case that we find a return patient.

In the majority of cases, we have reduced in this way the quarantine period to three weeks, thereby making a saving in time of twenty-five per cent., and in the course of the year this economy is noticeable.

Those who are engaged in health work, particularly in communicable diseases are convinced that medicine is not an exact science, and occasionally a case will arise that is not possible to explain. I have in mind one outstanding case of a young girl about seventeen who had the reddened throat, inflamed tonsils, strawberry tongue, temperature, typical scarlet fever rash. Cultures from her throat proved negative. I suspected the media and had new media made—still negative. We then found it possible to make our blood agar from human blood, and again it proved to be

negative. She went through the regular course and she desquamated. Why we didn't get a positive culture in her case I have no way of explaining.

The surgeon in charge of the Naval Training Station reported a case of a young recruit who had a typical scarlet fever rash—temperature, vomiting, etc. The cultures from his throat were found to be negative for s. h. s. The boy had been recently vaccinated, and the vaccination area had reached the pustular stage, and culture from the pus revealed the s. h. s., and the conclusion of the surgeon was that the portal of entry was through the vaccination area.

Bacteriologists claim that there are so many and varied strains of the s. h. s. that it is impossible to isolate the exact strain that produces scarlet fever. That may be true, and I do not know enough about bacteriology to attempt defense of what we are doing. My only point is that when we can associate the clinical and the cultural symptoms of suspected cases of scarlet fever, we have in the finding of the s. h. s. an impressive factor the like of which has not been known up to the discoveries of the Doctors Dick.

Our experience in the Health Department has been convincing, and we see no reason to change our methods, and it has in our case particularly been more satisfactory than any other method of handling the scarlet fever question. The methods are simple, they can be adopted in any community of any size, and with a little experience in reading the plates an element has been added to the handling of the case that cannot fail to be of value.

The preparation of the media is very simple. After heating agar-agar, a small amount of blood is added while the agar-agar is warm, and then poured upon a sterile Petrie dish. We have been using sheep cells because of the inability to always secure human blood, and a check up has found that it is just as satisfactory.

I understand that certain departments of the State will furnish these prepared plates for those who might be interested in this work, and I feel sure that when this method I have tried to outline is adopted it will give you a confidence in the diagnosis of doubtful scarlet fever cases that you have not experienced before. If nothing else was gained, this one fact justifies the adoption of this method.

## ANNOUNCEMENT

(By request)

### CHICAGO'S GREATEST RADIOLOGICAL CONVENTION

The Radiological Society of North America will hold its fourteenth Annual Convention in Chicago, December 3rd to 7th, inclusive, 1928. The Drake Hotel, Lake Shore Drive and North Michigan Avenue, has been selected as the headquarters. We are assured of ample accommodations and exceptionally reasonable rates and of the best and most efficient service.

Make your plans for this year include Chicago's greatest Radiological Convention. Every physician who is interested in this branch of Diagnosis and Therapy is welcome.

There are no registration fees, no additional expense. Plans are under way now to secure reduced transportation rates.

The Ladies' Local Reception Committee is making plans for the entertainment of all visiting ladies. These plans include theater parties, luncheons, shopping tours and sight-seeing trips, with generous hospitality extended to all visitors.

Much attention is being given to arranging for Scientific and Commercial Exhibits. These exhibits will afford a post-graduate course of instruction in nearly every branch of medical science. Clinics covering radiological problems, as well as other branches of medicine, will be given every day during the session. We are assured by the Program Committee of an instructive and interesting scientific session, and a program upon which will appear representative men from all sections of this country and Europe.

Start to make your plans to attend now. This means you. Many papers on General Diagnosis and Therapy will be read and discussed during the Scientific Session.

Bring the wife and family to Chicago, the hub of the United States, with theaters, parks, boulevards, and shopping districts second to none.

The location of our headquarters at the Drake Hotel will be found especially convenient. Therefore, make your plans to attend this meeting now. You cannot afford to miss this 14th annual Session of the Radiological Society at Chicago. Reservations should be made early. Communicate with Chairman of hotels and lodgings committee, T. J. Ronayne, M.D., West Suburban Hospital, Chicago, Illinois, or direct with Drake Hotel, Chicago, Illinois.

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**The R. I. Medico-Legal Society**—Last Thursday—January, April, June and October. Dr. Creighton W. Skelton, President; Dr. Jacob S. Kelley, Secretary-Treasurer.

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## EDITORIALS

### THE INVESTIGATION OF THE STATE INSTITUTIONS

Governor Case has acted very wisely in asking for a Commission to make an investigation of the affairs of the State Institutions. Rhode Island cannot afford to have a lack of public confidence in the management of those sick and unfortunate people who are committed to the State for its care. The members of this investigating committee, selected by the Governor, are citizens of the

highest type and the Governor by such appointments will win the approval of all right thinking residents of Rhode Island. Doctor James L. Wheaton, as the medical member, represents an exceedingly well qualified physician to carry out this work from the medical point of view.

It is to be hoped that the Commission will look upon the obligation imposed upon it as an opportunity for truly constructive service. The members of the medical profession know all too well the difficulties under which physicians serving the State work—small appropriations resulting in inadequate personnel, at times political pressure, and a partial absence of active and intelligent



public support makes these officials bear a tremendous load.

We feel sure that the whole matter will be looked upon from a broad point of view and that the responsibility of the citizens, the Legislature, the State Welfare Commission and the officials of the various Institutions will be clearly determined, and that a program can be laid before us that will restore public confidence and put Rhode Island in the forefront of the states in the care of its wards.

### PHYSICIANS IN PUBLIC

From time to time matters that are of interest to the public and the physicians are discussed and studied by groups of the laity, who more or less represent and mould public opinion. Frequently these matters are of great importance to public health and can better be sponsored by an impartial public spirited organization than by a body of medical men.

However, the lack of technical information in a group of non-medical men may render ineffectual efforts in a good cause and may even do definite harm. Further, medical men in such bodies may even initiate interest in well deserving medical causes that would otherwise be disregarded.

Well organized bodies such as the Chamber of Commerce, Kiwanis and Rotarians afford good opportunity for the physician to perform public spirited service without injecting himself into the public eye or running the risk of criticism.

### THE ANNUAL MEETING

One of the most interesting medical gatherings of local importance occurs during the month of June when the State Society holds its regular meeting which is followed by the annual dinner.

In the past this particular meeting has been a sort of gala day so far as programs and well known speakers were concerned because of the large attendance. Papers that have been read have done much to bring recent advancements in medicine to practitioners in Rhode Island who are unable to get to clinics in medical centers.

A valuable feature that is often overlooked, however, is association of the members with each

other, both before and after the dinner. Many new acquaintances are formed and often many new ideas are gained. Frequently foundations are laid for the carrying on of treatment of patients who have moved to other parts of the state. Above all the annual dinner leads to a fellowship and co-operation that is essential to the welfare and improvement in any medical society. Let us urge all who come to afternoon session to remain for the dinner.

### ADDRESS BY DR. WILLIAM S. SHERMAN OF THE NEWPORT MEDICAL SOCIETY

"Honored guests and members of the Newport County Society, I greet you on behalf of the Newport Medical Society and welcome you to our county, 'the cradle of American Medicine,' and to Newport, a city rich in medical and surgical history for nearly three centuries.

"Here Robert Jeffreys was authorized to exercise 'the function of Chirurgerie' in 1641, and John Cranston was 'by this Court styled and recorded Doctor of Phisick and Chirurgery' in 1664.

"Here too the first course of medical lectures in the colonies was delivered by Dr. William Hunter in 1756. Many of the highest medical commissions in the wars for our existence were held by men of this Town. Some of the earliest Hospitals were established here, and in 1798 one of the earliest Boards of Health. This library with its collection of medical books was established in 1747.

"The medical part of them was excellent; they were amply sufficient to give the medical student complete information, of all that was then known in the English language on Anatomy Surgery, Chemistry, and Botany, together with the history of drugs, and of their various preparation and uses, with the history of the progress of Physic from the time of Hippocrates. It sowed the seeds of the sciences, and rendered the inhabitants of Newport better read and inquisitive people than any other town in the British Colonies."

*(Quoted from a diary of the Redwood family)*

So it is fitting that we meet today in this ancient Redwood Library and Athenæum, probably the oldest library building in this country, a spot

hallowed by the memories of the profession for nearly two hundred years, an educational center before the founding of the great medical schools of Philadelphia, New York or Boston.

To this Temple of Learning and to our meeting we now welcome you whose mission is to Preserve Health, Prolong Life, and Soften Death.

The latter part of the eighteenth century has been termed the golden age of medicine in Newport. Dr. Benjamin Waterhouse alluding to this period says—"We doubt whether Boston, New York, or Philadelphia ever had, at one and the same time, two practitioners of physic and surgery, better educated and more skillful than these two gentlemen"—referring to Dr. Hunter and Dr. Halliburton.

Another who left the impress of his skill and conscientious investigation upon many pupils and followers is Dr. Jacques Gardette, a contemporary of Lafayette, who was commissioned as a surgeon in the French navy. An ardent patriot, of excellent education and charming manners, he arrived at Plymouth, early in January, 1778, as he himself expressed it for the sole object of fighting for the 'Holy Cause.'

After resigning from the French navy we find him in the little Army of the North, commanded by Lafayette, where he practiced general surgery and dental surgery, having studied the latter as a part of his profession of naval surgeon. When the French fleet and army arrived at Newport in 1780 he was induced to engage in practice in this town where he was well received and found considerable and congenial occupation.

We hear of him again in Providence in 1781-82, where the army was in winter quarters, and where besides his surgical service, he employed his knowledge of dental surgery in treating the officers and men. At that time he made the acquaintance of a young American surgeon, Josiah Flagg, also serving in the army, whom he initiated into the principles of dental surgery, in which Flagg took a lively interest.

We find Gardette in New York in 1783, where his limited knowledge of English proved a handicap to his success and it was not until the summer of 1784 and in Philadelphia that he attained the position which determined his permanent residence in the United States.

During that period he was befriended by Doctors Wistar, Shippen, Rush, and Kuhn. He con-

tinued in practice until 1829, when he returned to France and died at Bordeaux in August, 1831, at the age of seventy-five.

Jacques Gardette—Patriot—Naval Surgeon—Father of Dental Surgery in Our Country.

## THE CONTRIBUTION OF PSYCHIATRY TO PROBLEM OF CRIME\*

By WILLIAM A. WHITE, M.D.

SUPERINTENDENT OF THE ST. ELIZABETH'S HOSPITAL  
WASHINGTON, D. C.

One has some interesting experiences in going from place to place on occasions of this sort. The other day I was speaking in Philadelphia and cannot help but recall the comment of one of the gentlemen who spoke there to such a body as this, who were interested in crime and crime prevention and he congratulated the group on their interest and the object of their work and incidentally said they could not accomplish it by enthusiasm alone.

I am going to call your attention to the story of Adam and Eve. In their time the human family consisted of only two people, Adam and Eve, and there was but one law, and this law was broken, and broken by all the people who existed at that time, so we might as well say there was a 100% record of criminality. Such a record as that perhaps gives some reason for certain theologians believing that man is born in sin, but I suspect that he either is stupid or particularly smart and believe in him as I shall soon show.

In the first place I think it is fairly evident in the minds of most people throughout the country who read the newspapers that our method of criminality, penal method and laws on which they are founded are failing for some reason or other. Perhaps it is not too much to say that our Family has fallen down some way in existing affairs, and one wonders what the trouble is. My idea, and I think my idea is held by many who have fathomed this difficulty, is that the law and penal system by conservation and ultra-conservation has lagged too far beyond thought. Whereupon it

\*Read before the New England Society of Psychiatry, held in Providence, R. I., March 23, 1928.

remains that we need conservative elements in society. It happens in this instance that conservatism has been too prolonged, too wide a chasm in sentences forced upon us. While I have no idea that we can solve the question of crime offhand, but I am optimistic and I do believe that something can be done that is better than what is being done now, that it is not an adequate statement to say that since things have gone along so well for so long that there must be some good in them. There are very definite evidences that a change is being made along certain lines of endeavor. Take for instance this state of Rhode Island. In looking over statistics a short time ago I found that Rhode Island was one of the most backward states in the United States in the latter part of the last century in regard to caring for the mentally sick. Conditions were then lamentable in this respect. The hospitals did not have the confidence of the public. A great many seriously, mentally ill patients in the community could not be cared for. An example of what can be done if persistent effort is maintained year after year is now seen in the improvement of this condition as is shown by the announcement made tonight in regard to the new psychopathic ward. The same thing applies to crime. We are getting a line on the scientific idea as to what sort of individuals these people who commit crime are. I am quite convinced that the criminal, as he exists in the mind of the average individual, is simply a myth, and in their mind there is no such person. It is the same with the insane and the feeble-minded. Dr. Fernald gives this idea in one of his works when he says that a feeble-minded person is an absolute myth. For instance, a youngster may do something atrocious, and then be found to be feeble-minded, and so the ordinary person comes to think that all feeble-minded people are like that. Fundamentally, only a very few are like that, and, also, very few criminals are like the average person pictures them. What we hope to do is to turn this myth into reality, to try to understand what sort of an individual he is. By way of analogy, I would say: "If this country were being threatened with a serious pest that was destroying valuable property, what do you suppose would happen? First, the pest would be carefully studied, its whole life history from beginning to end would be gone into and it would be attacked only on a scientific basis of its life.

Yet, we attempt to deal with the problem of crime without any such information about the criminal, and we cannot be expected to make any impression on that problem until we have the necessary information. The legislation takes action on this, but increased punishment will not solve the problem. I have no faith in that method of procedure. It is an example of what usually happens when one is confronted by an unsolvable problem. They do something which they have been in the habit of doing before without realizing that conditions have changed. Personally, I do not look for any solution of the crime problem by increasing the sentences of serious offenders. Such a procedure, I believe, is doomed to failure.

Now let me tell you something about the crime situation as I have it in my mind. First, the most serious difficulty which we are confronted with is the attempt to find out what sort of individual the criminal is. The law makes no attempt to do this, but merely deals out a sentence without finding out the background of the criminal, and sentences him on the basis of the type of crime he has committed. This sort of thing is an absolute absurdity. Recently I was on a murder trial. A district attorney sentenced a man on the learnings and decisions of judges of a century ago, and asked the judge to be guided by those decisions. These conditions were made to apply to certain social conditions of those days, but are not applicable today. The law is apparently set on fixing a certain punishment for a certain act. I think the following story will illustrate more plainly than anything else the above facts:

A young man earning \$1,800 to \$2,000 a year married and had a family. They could just barely get along on it, but were living fairly comfortably, and making both ends meet. He was a perfectly respectable and good citizen. Suddenly there comes illness, there is need of doctors and hospitals, and expenses go on until he has no money left to get them. He knows nothing about the social agencies in his particular community to which he might go for information and assistance. In a fit of panic, he forges a check for \$100 in order to meet the emergency. He gets caught, and is sentenced to five years at State's Prison. What happens to his family? They are pauperized, forced to move to cheaper quarters in the tenement house district, the children are

taken out of school and forced to associate with children of the gutter, and so one can go on imagining what the future has in store for that family. They say a person is responsible for the natural consequences of his acts. Why, then, should a court bring more ruin than it can ever correct on a man? I don't quite see the logic of that sort of sentence. We want to think of the various individuals who compose society as so many assets. We want to think of them as investments by society, every individual an investment that society has made. It has brought that individual up, educated him, and prepared him for life in the hope that he may be a social asset. It is the worst kind of wastefulness to destroy that individual. They are learning in industrial systems not to discharge people without making inquiries into the difficulty to see what it is due to. Thus has mental hygiene entered into industrial plants. They are trying to see what the matter is with a person when his work is falling off; they are beginning by correcting the little things. We should hold the same sort of responsibility toward people who run counter to criminal law. We must not start off trying to understand the problem of crime with the idea we can fix it all up by a few laws that everyone must obey.

In regard to that myth, the criminal. Judges are beginning to appreciate this thing. There is a growing co-operation; they are beginning to see our point of view a little better; they are seeing the medical point of view a little better; and so lawyers and doctors are discussing this problem in a common way, and thus each one is understanding the other one better. Now they are talking in terms which each one understands. Out of all this comes the frank and honest statement from the judges that "We don't know what we are doing. If you psychiatrists can help us, then do it. We need help." The psychiatrist feels a little bit apprehensive because the demands are very great. We don't think that we have the solution of the crime problem. Not at all. The judge and the psychiatrist must work together. In that way they can do much better than they are doing now. One of the fundamental things in which the lawyer and doctor misunderstand each other is in reference to certain concepts which I think are basic; they are guilt, responsibility and punishment. The law talks very glibly about responsibility and irresponsibil-

ity and punishment. The doctor is never quite so sure about those things. Whether or not a human being is responsible cannot be judged by another person. You never can know enough about him.

I believe that we are still dealing with the criminal on the basis of getting even with a fellow who has done something to us that we do not like or approve of.

Did you ever go through a prison? There are good and bad prisons; some are better than others, and then, some are very bad. I doubt very much if the best of them would have any reformatory effect on the criminal. Some of the very old prison systems were based on a discipline that demanded absolute silence on the part of the prisoner. That, of course, is being rapidly done away with. You could never reform anyone in an atmosphere of that sort. Some prisoners are placed in solitary confinement. To my mind, conditions of prison life as they stand make rehabilitation of the criminal impossible. The very things are done that make it impossible to have any concrete results. I am going to give you another example, as I think examples always explain a point better.

I have in mind a man who is now over fifty years of age. When he was seventeen years old, he was living on a farm in a middle western state. His father died, leaving a widow and several children. The seventeen year old boy took charge of the farm, his mother and the children, and took over all of his father's debts, which he paid, educated the children, and in every way conducted himself in the way all orderly citizens should. This family adhered to a very rigid and strict religion. They were taught to read from the Bible by their mother. In the course of time, this boy married and had his own home and family, and he taught his own children as he had been taught. He was always a good citizen, even though all this responsibility had tended to make him a little odd, and he did not mix with the people. One day his nineteen year old daughter met a young man, with whom she went off and who assaulted her. Of course, the girl comes to her father with the story. The father becomes very much enraged, and starts off in a mad frenzy to find the young fellow. No one could stop him. He did find the boy, and killed him. He, naturally, was arrested and put in jail, and he could remember nothing of the incident



Would you put this man in the same category with others who, perhaps, had committed a similar act, but with an entirely different background and entirely different circumstances? If you are going to consider crime, consider both sides of the equation. Take into account all the past of the criminal, understand his education, social conditions, pry into the situation which caused the crime. If you are reading books of recent publication by psychiatrists that deal with these problems, you will find that they are dealing with it this way. It is absurd to raise the question of responsibility. One does not want to approach the question from that angle.

Law needs to be socialized. Psychiatry is socialized.

I am going to quote another example: A young fellow, seventeen or eighteen years of age, had been going to school, and got along very nicely up to the fifth grade, but did not do so well after that. People thought he was lazy. However, he was promoted, and he had a young teacher in this grade whom he pestered with a good deal of attention, until he finally proposed marriage. She became rather alarmed, and tried to avoid him. Finally, in due course of time, she became engaged to a man of her own choice. The boy did not like this at all, and came to her with an insistent, flat proposal—he wanted to marry her, and did not want to have her marry anyone else. She complained to the police, and caused the boy to be arrested. The only result of this was that the judge told the boy to leave the jurisdiction. Looking at it from our point of view, twenty-five years afterward, how stupid and how utterly useless this was. Of course the boy left the jurisdiction. He merely went into the next one, bought a gun, came back, and, meeting the teacher, shot her to death. I do not know whether a psychiatrist would have been able to avoid this or not, but at any rate, he would have made a different decision, and the psychiatrist is more often right than the court.

The primary function in a criminal court, after all, is to protect society. After society, then the individual. Therefore, to do this, the courts need to have agencies at work who are trained in this sort of thing. They should do it at a 100 per cent. rating, but at any rate, they could do it better than it is being done now.

The following are some of the recommendations on this phase as given by the American Psychiatric Association:

The first object should be the protection of society;

The second is the rehabilitation of the prisoner;

Detention, if rehabilitation is impossible;

Detection and prevention of objective.

The following are some recommendations that I would give:

When a case comes up in court, the psychiatrist should present the true story of the criminal's personality and social significance;

Try to salvage the prisoner, to protect society, and to be constructive and "save the pieces;"

Do not bring in a diagnosis of responsibility. That does not help;

The attachment of psychiatrists to courts, parole boards and prison staffs;

Commitment of offender to Board of Public Welfare for an indeterminate period of time for certain classes of crime;

Necessity of prison reform;

Remove prisons from political control.

As a closing suggestion, I think it would be a good idea if all district attorneys and judges were sent to prison for a while to live and get the atmosphere of prison life, and study the prisoner at right hand. We doctors, after we get through our course in medical school, are required to live in a hospital for a year so that we may know something about the way they are run, and learn more about the sick people who inhabit them.

#### CASES OF HYPERTENSION STUDIED WITH THE AID OF THE OPHTHALMOSCOPE\*

By DR. HARRY MESSENGER  
PROVIDENCE, R. I.

An extensive essay on the subject of Hypertension is not my purpose.

From a series of cases, I have chosen five, describing the appearance of the retinal arteries, Medical Diagnosis, urinalysis, blood-pressure, age and other significant findings. These cases are

\*Read before the Providence Medical Association February 6th, 1928.



chosen particularly as illustrating that, regardless of complications or other factors, the retinal arteries give a very good index of the degree of arterio-sclerosis present in other organs as well as the retina.

The arteries in the retina are endarteries, corresponding in structure to endarteries in the pancreas, brain, kidney, etc. Exhaustive studies of the retinal arteries have been made, notably by R. Foster Moore, of London, an ophthalmologist, and O'Hare and Walker of Boston, internists. They, and others, have concluded that the essential lesion in Hypertension is a contraction of the smallest arterioles, and that this change takes place simultaneously all over the body; changes in the larger arteries come on, after a time, also in equal degrees in various parts of the body. As the retina is the only place, except the conjunctiva, where the progress of arterial disease can actually be seen, you readily appreciate that the condition of the retinal vessels as seen by the ophthalmoscope reveals also the condition of the arteries in the kidneys, brain, etc. With normal retinal arteries, you have normal renal arteries (but not necessarily normal kidneys).

The changes, as seen in the arteries undergoing sclerosis are as follows:

1. *White Reflex* from the arterial trunks, differentiated from the juvenile reflex which occurs up to thirty years of age and is merely a specular reflection of light from the smooth surface of the retina and is seen equally on the veins and arteries. In arterio-sclerosis, the reflex is seen only on the arteries.

2. *Increase of the White Reflex* until the arteries look like glistening wires, copper-wire if the caliber of the artery is still nearly normal, silver-wire if the caliber is much reduced.

3. *Narrowing.* A narrowing of the blood stream. There is a greater difference than normally between the size of the blood stream in the veins and the arteries.

4. *Pressure Effect.* A sclerotic artery crossing a vein displaces the vein causing, in appearance, a definite narrowing of the lumen of the vein and, if great, an apparent obliteration of the vein extending sometimes an appreciable distance to either side of the artery. I say "apparent" because most of the appearance is due to displacement of the vein rather than compression.

5. *Later Changes* are increased pallor of the artery, marked narrowing of the stream, a beaded appearance due to unevenness in caliber and tortuosities of the smaller branches.

6. *Still Later Changes* are small hemorrhages from terminal branches, small exudates and larger hemorrhages.

7. *Perivasculitis.* White strips along the vessels. Some vessels may be converted into white threads.

8. *Oedema of the Disc* with atrophy of the retina, a degeneration of the macula with deposits of pigment.

Blocking of the central artery or a branch may occur before these changes have advanced beyond the earlier stages.

Good vision may be retained even in well-advanced cases.

*Choroidal Sclerosis* present a different picture. The choroid is practically a plexus of vessels intercommunicating and forming almost an erectile tissue. Sclerosis produces a sharply outlined tessellation of the fundus, general pallor and a yellowish pallor of the disc. When hemorrhages occur, they are large and seen underlying the retinal vessels.

Sclerosis of the choroid is associated with peripheral sclerosis, sclerosis of the radials, temporals, etc. Occasionally, it is seen in one eye and not in the other, and sometimes only in one sector of the eye-ground. The retinal arteries always show the same degree of sclerosis in both eyes and throughout the retinae.

The first two cases which I shall describe are cases of Hypertension, complicated only by conditions which may be considered directly due to the increased arterial tension and sclerotic changes. Some of the results of Hypertension are Cardiac Hypertrophy, Nephritic changes, which have been known as Interstitial Nephritis, Cerebral Hemorrhage, Angina Pectoris, Congestive Failure of the Heart, Uremia and Diabetes. For a good description of Hypertension and an interesting conception of it, based largely on facts and partly on theory, I refer you to an article in the *Boston Medical and Surgical Journal*, July 28, 1927, by James P. O'Hare, entitled "The Development of Cardio-Vascular-Renal Disease." The third and fourth cases are of Hypertension of this type, with complications; and the last case, Hypertension not of this type.

*First Case.* Susie C—— from the Medical Out-Patient Department of the Rhode Island Hospital.

Age 70. Diagnosis: Hypertension  
 Urinalysis: Specific Gravity: 1.008  
 Albumen: Absent  
 Sugar: Absent  
 Sediment: No Casts  
 Blood Pressure 230  
 125

The retinal arteries show an increased reflex, narrowing of the blood-stream, marked pressure effect, tortuosities of the arteries and veins, no hemorrhages or exudates.

This is a case typical of the great group Hypertension. The age is above the average of the series; there is a low gravity urine, high systolic and diastolic blood pressure. Narrowing and marked pressure effect in the arteries show well-advanced changes in the arterial walls. "Tortuosities" is not a reliable sign, but goes with the high blood-pressure and marked thickening of the arterial wall as shown by the great pressure effect. Low gravity urine is an almost constant finding in these cases.

*Second Case.* Pedro M—— from the Medical Out-Patient Department of the Rhode Island Hospital.

Age 61. Diagnosis: Hypertension.  
 Urinalysis: Specific Gravity: 1.019  
 Albumen: Absent  
 Sugar: Absent  
 Sediment: No Casts  
 Blood Pressure 190  
 115

Pupils react to light and not to distance.

Retinal arteries are narrow. There is a beautiful silver-wire reflex and marked pressure-effect, slight tortuosities. No hemorrhages or exudates.

This man is nine years younger than the first patient but his case is perhaps more advanced. *Silver-wire* reflex means a very marked reflex indicating much new tissue in the arterial wall. He also has narrowing and marked pressure-effect where an artery crosses a vein. The urinary gravity is very rarely as high as 1.019 in these cases. The pupillary reaction to light but not to distance has nothing to do with Arterio-

sclerosis, but is an interesting sign common after Encephalitis, which he has had.

*Third Case.* Rosa D—— from the Medical Out-Patient Department of the Rhode Island Hospital.

Age 50. Diagnosis: Hypertension  
 Auricular Fibrillation  
 Obesity  
 Urinalysis: Specific Gravity: 1.010  
 Sugar: Absent  
 Albumen: Absent  
 Sediment: Rare hyaline cast

Blood Pressure 230 140  
 120 90

The retinal arteries show a copper-wire reflex, some narrowing, a slight pressure effect—no tortuosities, hemorrhages or exudates. This woman has been under observation for nine months; her weight has fallen from 250 to 150 pounds. Her blood-pressure has ranged from 250 to 140 with  
 120 90

ups and downs, but with lower readings recently. The arteries do not show as advanced changes as the two cases I have just described. One suspects that the pressure does not vary in them as in this case. This woman has no bad symptoms now. It seems to me from observing a number of such cases that in obese patients who lose weight the hypertensive arterial changes proceed slowly.

*Fourth Case.* Irma F——, Services of Dr. DeWolf, Ward H, Rhode Island Hospital.

Age 64. Diagnosis: Diabetes  
 Urinalysis: Specific Gravity: 1.020  
 Albumen: Trace  
 Sugar: Present

Blood Pressure 150  
 90

Retinal arteries narrow-pale, some brilliant reflex, slight pressure effect. The complication here is Diabetes, in fact, Diabetes is the disease, but there are definite arterio-sclerotic changes, particularly narrowing and reflex. Diabetes lowers the blood-pressure in these cases and the urinary picture is altered by the presence of sugar.

It seems that all patients with this arterio-sclerosis are potential diabetics.

A mild glycosuria is very common in these cases.

*Fifth Case.* William D——. Private Case.

Age 19. Diagnosis: Chronic Nephritis of 3 years' duration, beginning as a definite Acute Nephritis, with suppression of urine, bloody urine with casts, oedema, etc.

Urinalysis: Specific Gravity: 1.006  
Albumen: 2% by volume  
Sediment: Granular casts

Blood-Pressure 195  
135

He is now working as a clerk and feeling well, but on a low protein diet and feels compelled to drink a lot of water.

*Retinal Arteries* appear to be normal.

This is a case of chronic nephritis and the Hypertension and cardiac hypertrophy are the results of renal disease. If persistent Hypertension is the cause of arterio-sclerosis, why doesn't this case show changes in the vessels after three years with a systolic blood-pressure, usually 200 or more? Young arteries are not so vulnerable and tension is not the only factor in producing changes.

In Nephritis, as you know, we sometimes see the so-called albuminuric retinitis with hemorrhages and exudates. The theory of H. Batty Shaw, an English internist, is that such changes are due to a severe, acute toxemia which knocks holes in the arteries quickly while in the arterio-sclerotic changes, we have the prolonged action of minute quantities of toxins the nature of which we can, as yet, only question. Heredity is considered to be an important etiological factor.

In closing, let me urge the use of the ophthalmoscope in these cases, the technical difficulties are few and within a short time you can learn to observe directly changes in the vessels. Studies by this method have been valuable to men trying to understand this great class of cases, because by observing the changes in the vessels they have been able to form a very clear idea of the extent to which arterio-sclerosis has progressed in the arteries of the retina, kidney and brain, and sometimes to tell whether or not a weak myocardium is so because of breaking down under long continued strain of Hypertension or from other causes.

In a given case, knowledge thus obtained may be of great help.

## SOCIETIES

### PROVIDENCE MEDICAL ASSOCIATION

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Edward S. Brackett, Monday evening, May 7th, 1928, at 8:45 o'clock. The records of the last meeting were read and approved.

The first paper of the evening was read by Dr. Albert H. Miller on "Post-operative Complications." When is appendectomy in the course of hysterectomy justifiable. Deductions from 556 cases of hysterectomy compared with 934 cases of appendectomy. In Dr. Miller's anesthesia cases he examines them before operation and follows them afterwards for complications. Slides were shown giving figures which seemed to show that pulmonary and circulatory complications are more frequent after gas oxygen than after ether, but this is markedly affected by the type of operation. Appendectomy is certainly indicated in selected cases of hysterectomy but more frequently with super-vaginal. The paper was discussed by Dr. Perkins, Dr. Noyes, Dr. Brackett and Dr. Miller. Dr. Gifford presented a frozen specimen of a mesenteric cyst taken from a five-year-old patient. There was gangrenous gut. This was a cholesterine cyst.

The second paper of the evening was by Dr. Frank B. Berry of New York City on "Lung Abscess" based on a large series from the Columbia section at Bellevue Hospital. He first described the formation and repair of lung abscess. One school considers it always embolic in origin. The other school considers it due to aspiration of infectious material. He considers it may be produced in either way. They find many cases apparently ideopathic. Numerous organisms have been found. Prognosis is best when treatment is started early. The principal symptoms are pain in chest, cough and sputum. Physical signs are frequently very slight. Clubbing of the fingers and toes often occurs. Treatment: 1. Postural. 2. Bronchoscopic. 3. Pneumothorax. 4. Surgery. Do not confine to one method of treatment, put to bed; explain treatment to patient and use posture several times daily. This alone often cures. Bronchoscopy has danger even in skilled

hands and is held in reserve. Pneumothorax benefits in centrally located abscesses. Used with great care. Arsphenamin treatment is doubtful as yet. Must be used very early. Optional time for surgical treatment is just before the wall begins to organize. Brain abscess and hemorrhage and fistulae are prone to occur after this. Conservative treatment has improved their mortality figures but they are feeling now that they may be getting too conservative. Almost 70% of cases now may be cured. An interesting series of slides was shown with pathological pictures, X-rays and tables. The paper was discussed by Drs. Fulton, Keefe, Ventrone, Belliotte, Batchelder and Berry.

Meeting adjourned at 10 P. M. Attendance 80. Collation was served.

PETER PINEO CHASE, *Secretary*

#### NEWPORT COUNTY MEDICAL SOCIETY

The annual meeting of the Newport County Medical Society was held in the Redwood Library, March 29th, 1928, with a large attendance of members and many guests.

At the opening of the meeting Dr. William S. Sherman, President of the Society, gave an address of welcome which will be found upon another page.

After reports of various committees the resignation of Dr. A. W. Stevenson, long an active member of the Society, was received and accepted with regret. Dr. John Ridlon was elected to membership.

The election of these officers followed:

Honorary Presidents—S. Cambreleng Powell, M.D.

President—D. P. A. Jacoby, M.D.

First Vice President—John A. Young, M.D.

Second Vice President—Frederick A. Asserson, M.D.

Secretary—A. Chase Sanford, M.D.

Treasurer—John H. Sweet, M.D.

Councillor of R. I. State Medical Society—Edward V. Murphy, M.D.

Censor—Samuel Adelson, M.D.

At the La Forge the guests of the Society who also attended the meeting at Redwood, were the officers of the Rhode Island State Society. President, Norman M. McLeod, M.D.; First Vice President Arthur N. Harrington, M.D.; Second

Vice President Frank F. Fulton, M.D.; Secretary James W. Leech, M.D.; Treasurer James Mowry, M.D. The Naval hospital was represented by Captain William H. Bell, M.D., and numerous other members of the hospital staff. Fort Adams was also represented.

Following the banquet, remarks were made by the newly elected President, Dr. Jacoby, the officers of the State Society and by Captain Bell.

## HOSPITALS

#### THE MEMORIAL HOSPITAL

MEETING OF THE MEMORIAL HOSPITAL STAFF  
HELD MAY 3, 1928

Meeting called to order at 9:25 P. M. by President Wheaton.

Minutes of previous meeting read and approved.

The records were approved, having been gone over at a previous meeting of the Executive Committee of the Staff.

The Resolution Committee submitted resolution on the death of Lester J. Gilroy, M.D. The report of the Committee was accepted and it was voted to inscribe a copy of this resolution on the records, a copy forwarded to Mrs. Gilroy and a copy to be forwarded to the Editor of the *Rhode Island Medical Journal* for publication.

A motion was made by Dr. Miller, seconded and passed, as follows:

It is recommended that the Chairman appoint a Committee of three to present to the Staff at the end of the hospital year a compilation of the Medical and Surgical work done at this hospital for that time.

The speakers of the evening were Drs. F. V. Hussey and J. E. Kerney.

Dr. Hussey presented two cases of Pyloric Stenosis operated at this hospital in the last ten days. Dr. Kelly assisted by giving medical history of the cases and Dr. Batchelder exhibited X-Ray films.

The speaker presented an interesting case of Adeno-Carcinoma of the Stomach, showing the specimen removed and pre-operative X-Ray films.

Discussion was led by Dr. A. T. Jones and Dr. C. H. Jameson.



Dr. Kerney then presented two Urological cases: one case of Pyelonephrosis of the right kidney containing large stones and accompanied by complete destruction of kidney tissue; one case of Pyelonephrosis with stone, having T. B. Bacilli present in the pus.

The speaker emphasized the need of early complete urological examination.

Discussion was opened by Dr. C. H. Jameson.

Speakers were extended thanks of the Staff by President Wheaton, who also appointed the following committee on records: Dr. A. H. Miller, Chairman; Dr. W. P. Davis and Dr. S. Sprague.

Adjourned at 10:35 P. M.

STANLEY SPRAGUE, M.D.

*Secretary, pro tem.*

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## OBITUARY

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LESTER JAMES GILROY, M.D.

The Memorial Hospital Staff Association has learned with profound regret of the death of Doctor Lester J. Gilroy on April 2, 1928, after a brief illness from septicaemia. He was born in Attleboro, Massachusetts, on March 31, 1898, and reached his thirtieth birthday but two days before his death. He was graduated from Tufts Medical School in 1920 and served internships of one year at the Carney Hospital, Boston, and six months at the Providence City Hospital. He then settled in Pawtucket and engaged in the general practice of medicine, soon after this becoming a member of the Pawtucket Medical Association, the Rhode Island Medical Society, and the American Medical Association. He had served as Secretary of the Pawtucket Medical Association for two years, and had only recently been elected its Vice President. He had served as physician to the Out-Patient Department of the Memorial Hospital for six years, where his work was thorough and painstaking. He was examiner for the Metropolitan Life Insurance Company. Doctor Gilroy was a member of the Phi Chi medical fraternity and the Knights of Columbus, but otherwise was not affiliated with any social or fraternal organizations. He married Miss Helen McCaffrey of Attleboro, Massachusetts, and is survived by her and one daughter, three years of age.

Doctor Gilroy was a man of quiet and unassuming demeanor, who endeared himself to all with whom he came in contact by his charm of manner and his thoughtful interest in the welfare of others. He was profoundly interested in the practice of his profession and his work in the Memorial Hospital had been of a high order of merit. He was fond of his family and friends, but had never sought public office. The circumstances of his illness were particularly tragic and his death was a tribute to the quiet heroism of the profession in the face of duty.

The Staff Association extends the heartfelt sympathy of its members to his family and desires to spread this memorial upon its records.

ROLAND HAMMOND, M.D.

CHAS. F. SWETT, M.D.

ROBERT T. HENRY, M.D.

*Committee*

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## BOOK REVIEWS

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AMERICAN MEDICINE AND THE PEOPLE'S HEALTH, by Harry H. Moore. Published by D. Appleton & Company.

This book is a cold-blooded survey of the organization of medicine in the United States, private and state, curative and preventive. The large scope of this work allows of only a presentation of the facts as are, without much discussion. This gives one a sense of disjointment on reading the book. However, on closer study, one can see that the author has really arranged his material in a logical sequence. The appendices of 250 pages, one-third of the entire book, help to give added facts supporting the original text. This makes the book valuable for reference, especially to those actively engaged in the practice of medicine and public health.

For the general practitioner, part two containing the chapters on "*The Manifestations of the Maladjustment in Medicine*" makes interesting reading. He will also get much food for thought in reading the chapter on clinics.

The chapters dealing with costs are interesting. It is rather refreshing to think that for \$25.00 a year, under proper organization, a family can get all the necessary medical attention it needs. The physician also seems to do very well under this organization.

There are many interesting facts in this book although on the whole they make rather dry reading matter unless one likes statistics.